Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TX 77504

Respondent Name
DALLAS ISD

Carrier's Austin Representative Box
19

MFDR Tracking Number
M4-10-0551-01

MFDR Date Received
SEPTEMBER 21, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On or about October 15, 2008, Provider submitted its bill marked, 'Separate Reimbursement to Hospital for Implantables Requested.' Provider requested separate reimbursement for implants and all required documentation has been submitted to the Carrier. On or about November 24, 2008, Carrier sent Provider an Explanation of Benefits and included payment in the amount of $52,422.09. On or about August 7, 2009, Provider timely sent Carrier a Request for Reconsideration noting that Carrier failed to reimburse Provider pursuant to the applicable sections of the Hospital Facility Fee Guideline when Provider requests separate reimbursement for implantables, specifically, 28 TEX. ADMIN. CODE section 134.404(f)(1)(B). Provider incorrectly calculated the DRG value on its Request for Reconsideration when it requested additional reimbursement from the Carrier in the amount of 9,848.23, plus interest. On or about September 07, 2009, Carrier sent Provider an Explanation of Benefits denying any additional reimbursement after reconsideration…In this case, if calculated pursuant to section 134.404(f)(1)(B) and (g), reimbursement should be **$133,108.77**…The Carrier made a partial payment of **$52,422.09**. Therefore, the Carrier is required to reimburse Provider an additional amount of **$80,686.68**, plus any and all applicable interest."

Amount in Dispute: $80,686.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No additional allowance is recommended…in calculating the hospital reimbursement the billed charges for implants $109,431.00 was deducted from the total billed amount of $289,284.77 leaving a balance of $179,853.77. Using the facility amount of $179,853.77 the Medicare reimbursement is $48,538.97. Since the provider requested separate reimbursement for implants the facility specific reimbursement was multiplied by 108%. The previous total reimbursement of $54,422.09 is correct. The bill was initially audited on 11/14/08. No allowance was recommended for implants, as the provider did not enclose the required certification statement. The bill was processed for reconsideration on 09/01/09. However, the provider did not submit the required certification statement for implants and no additional allowance was recommended."

Response Submitted by: Dallas ISD Risk Management, 3700 Ross Avenue, Box 91, Dallas, TX 75204

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 22, 2008 Through September 27, 2008	Inpatient Hospital Surgical Services	$80,686.68	$26,880.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f)(2) and (g) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. 28 Texas Administrative Code §134.404(g)(1) states that "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 14, 2008
   - W1G — Workers Compensation State Fee Schedule Adjustment. *Reimbursement per the Hospital Facility Fee Guideline – Inpatient Rule 134.404. Prior to admission date March 1, 2008, Rule 134.401.*
   - W1KA — Workers Compensation State Fee Schedule Adjustment. *Reimbursement per the Hospital Facility Fee Guideline – Outpatient Rule 134.403.*
   - 97H — The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. *Service(s)/Procedure is included in the value of another service/procedure billed on the same date.*
   - 16L — Claim/service lacks information which is needed for adjudication. *Implants require a statement of

certification. For ASC Rule 134.402; Outpatient Hospital Rule 134.403; Inpatient Hospital Rule 134.404*
- 16K — Claim/service lacks information which is needed for adjudication. *Please submit copy of invoice.*

Explanation of benefits dated September 1, 2009
- 193 — Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W1G — Workers Compensation State Fee Schedule Adjustment. *Reimbursement per the Hospital Facility Fee Guideline – Inpatient Rule 134.404. Prior to admission date March 1, 2008, Rule 134.401.*
- 97H — The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. *Service(s)/Procedure is included in the value of another service/procedure billed on the same date.*
- 16L — Claim/service lacks information which is needed for adjudication. *Implants require a statement of certification. For ASC Rule 134.402; Outpatient Hospital Rule 134.403; Inpatient Hospital Rule 134.404*
- Comments: REIMBURSED AT 108% APC RATE – NO CERTIFICATION STATEMENT SUBMITTED FOR THE IMPLANT INVOICES.

Issues

1. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
2. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
3. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
2. The Carrier asserts that reimbursement was not recommended for the disputed implantables, as the as the provider did not submit the required certification statement as required under DWC rule 134.404 (g)(1). However, review of the submitted documentation submitted for medical fee dispute resolution, finds a request for separate reimbursement of implantables in accordance with 28 Texas Administrative Code §134.404(g).

   A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $109,431.00.

   The Division finds that total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Cost Invoice	Cost + 10%
Screw Cancellous	1	No Invoice Submitted	$0.00
Graft Infuse Bone	1	$5,250.00	$5,775.00
Cage/Spacer	1	$7,500.00	$8,250.00
Bone Infuse Small	1	$3,350.00	$3,685.00
Screw Polyaxial	2	$2,990.00	$3,289.00
Screw Polyaxial	2	$2,990.00	$3,289.00
Set Screw Cap	5	$2,000.00	$2,200.00
Rod Pre-Bent	2	$800.00	$800.00
TOTAL	15		$26,880.00

3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011." Reimbursement for the disputed services is calculated in accordance with 28 Texas Administrative Code §134.404(f)(1)(A) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 455 is $48,538.97. This amount multiplied by 108% is $52,422.09. The total net invoice amount (exclusive of rebates and discounts) for the disputed implantables is $24,880.00. The total add-on amount of 10% or $1,000 per

billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $2,000.00. The total maximum allowable reimbursement (MAR) is therefore $79,302.09. The respondent previously paid $52,422.09, therefore an additional amount of $26,880.00 is recommended for payment.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $26,880.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The division hereby ORDERS the respondent to remit to the requestor the amount of $26,880.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		September 28, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		September 28, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.